Department Of Health And Human Services MAINE CARE HOME HEALTH ADMIT/DISCHARGE FORM (AGE 21 AND OLDER)

Member:		Provider Nam	e:
MaineCare Number:		Provider Telephone:	
Provider Contact Person:		Provider Fax:	
Please indicate <u>all</u> payer sources available to this consumer, even if not currently being utilized:			
☐ Medicare ☐ MaineCare	e □Othe	er	
Check Box: \Box 1 st Certification Period/// \Box 2 nd Certification Period/// \Box 3 rd Certification Period*/// \Box 4 th Certification Period*///			
*Note: Services provided beyond the first and second certification period require prior authorization which is obtained by requesting a medical eligibility determination assessment from Goold Health Systems.			
NURSING SERVICES:	Start of Care	End of Care	Psychiatric Medication Services ONLY:
 □ RN-Skilled Nursing □ Home Health Aide □ MSW (Not allowed as stand alonemust also have RN,PT,OT or ST) THERAPIES: □ Physical Therapy □ Occupational Therapy □ Speech Therapy 			Member has severe and disabling mental illness that meets the eligibility requirement set forth in Section 17. The only service covered is medications administration or monitoring. (ANY ADDITIONAL HOME HEALTH SERVICES REQUIRE PRIOR AUTHORIZATION UNDER THIS EXEMPTION) Start of Care End of Care PRIOR AUTHORIZATION REQUIRED AFTER THE FIRST 120 DAYS FOR ALL CATEGORIES OF SERVICES IN THIS SECTION, EXCLUDING PSYCHIATRIC MEDICATION SERVICES
Discharge Disposition Long-term Care Program (name) Home, no service Hospital Facility (name) Deceased Person Completing this form:			Final Home Health End Date Date Date Date Date Date Date Date Date

Notes: